# Reference Manual

## Information for Branch Managers on **Fixed Indemnity Medical Plan**

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LGS
Insurance Applications Group, Inc.

v.19.0

# Contact Information

## Branch Services:

**We have a single toll-free number and a single email address for you to use to submit your inquiries. Please contact the Essential StaffCARE Support Center at 1-844-262-6022 or via email at escsupport@paisc.com.**

**Representatives are available Monday – Friday from 8:30 a.m. – 5:00 p.m. ET.**

Secondary Contact: 704-637-0022 – Essential StaffCARE Account Management
Use this contact in the event that the Primary Marketing Service Support Representative is unavailable and you are in need of immediate assistance. We ask that employees not call this number as it is reserved for management.

## Member Services:

Essential StaffCARE Customer Service: 1-866-798-0803
Members will call this number for questions regarding their plan coverage, ID Card, claim status, policy booklets, and to cancel or change their coverage
Customer Service Call Center hours are M-F 8:30am to 8:00pm EST
Spanish Speaking representatives are available

## Interactive Voice Response (IVR):

### How To Make Changes and Cancel Coverage by Telephone

After your initial enrollment form has been submitted, you may make changes or cancel coverage by telephone. Changes can be made within 30 days of completing your enrollment form. If you do not have an assignment during the first 30 days, you can make changes to your coverage within 30 days from the pay check date of your first assignment. You will be prompted to enter your PIN CODE plus the last four digits of your social security number.

PIN CODE: 142 + _ _ _ _ (last four digits of your SSN)

Call 1-800-269-7783 (toll free) to make changes or cancel coverage by telephone. You may cancel or reduce coverage at any time unless your deductions are pre-tax. Remember, it will take two to three weeks for the changes or cancellation to be reflected on your paycheck. Coverage will continue as long as you have a paycheck deduction and refunds will not be issued for this time period.

# Fixed Indemnity Medical Benefits - Plan 2

| Plan 2 | |
|---|---|
| Medical Network | First Health |
| Network Provider Must Accept Plan | Yes |
| Prescription Network | Caremark |
| Pre-Existing Condition Limitation | None |
| **Wellness Care** | |
| Wellness Care (one per year) | $100 |
| **Inpatient Benefits** | |
| Standard Care | $500 per day |
| Intensive Care Unit Maximum [1] | $600 per day |
| Inpatient Surgery | $3,000 per day |
| Anesthesiology | $600 per day |
| First Hospital Admission (1 per year) | $250 |
| Skilled Nursing *(for stays in a skilled nursing facility after a hospital stay)* | $100 per day |
| **Outpatient Benefits [2]** | |
| Annual Outpatient Maximum | $2,000 |
| Physician Office Visit | $100 per day |
| Diagnostic (Lab) | $75 per day |
| Diagnostic (X-Ray) | $200 per day |
| Ambulance Services | $300 per day |
| Physical Therapy, Speech Therapy, Occupational Therapy | $50 per day |
| Emergency Room Benefit - Sickness | $200 per day |
| Emergency Room Benefit - Accident [3] | $500 per day |
| Outpatient Surgery | $500 per day |
| Anesthesiology | $200 per day |
| **Prescription Drugs** (via reimbursement) [4, 5] | |
| Annual Maximum | $600 |
| Generic Coinsurance | 70% |
| Brand Coinsurance | 50% |

*[1] Pays in addition to standard care benefit [2] All outpatient benefits are subject to the outpatient maximum [3] Covers treatment for off the job accidents only [4] Not subject to outpatient maximum [5] To file a claim, save your receipt and remit to Planned Administrators, Inc.*

| Weekly Premiums | Medical |
|---|---|
| Employee Only | $20.91 |
| Employee + Child(ren) | $34.71 |
| Employee + Spouse | $39.73 |
| Employee + Family | $52.90 |

# Dental, Vision, Term Life, Short Term Disability, & Accidental Loss Benefits

| Accidental Loss of Life, Limb & Sight | | | |
|---|---|---|---|
| Employee Amount | $20,000 | Child Amount (6 mos to 26 yrs old) | $5,000 |
| Spouse Amount | $20,000 | Infant Amount (15 days to 6 mos) | $2,500 |
| Accidental Loss of Life, Limb & Sight is part of the Medical Benefits | | | |

| Dental Benefits | | | | | | |
|---|---|---|---|---|---|---|
| | Waiting Period | Coinsurance | Annual Maximum Benefit | $750 | Deductible | $50 |
| Coverage A | None | 80% | Exams, Cleanings, Intraoral Films, and Bitewings | | | |
| Coverage B | 3 Months | 60% | Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures | | | |
| Coverage C | 12 Months | 50% | Periodontics, Crowns, Endodontics, Bridges and Dentures | | | |

| Vision Benefits | | |
|---|---|---|
| | In-Network | Out-of-Network |
| Eye Examination for Glasses [1] (including dilation) | Copay: $10, plan pays 100% | Plan pays $35, you pay remainder |
| Frames [2] | Plan pays $110 allowance [4] | Plan pays $55 |
| Standard Plastic Lenses for Glasses [1] | Copay: $25, plan pays 100% | Copay: $0, plan pays $25-$55 [3] |
| Standard Contact Lens Fit [1] | You pay up to $55 | You pay 100% of the price |
| Premium Contact Lens Fit [1] | Plan pays 10% off the price | You pay 100% of the price |
| Contact Lenses or Disposable Lenses [1] | Plan pays $110 allowance [4] | Plan pays $88 |
| Contact Lenses Medically Necessary [1] | Plan pays 100% | Plan pays $200 |

| Term Life Benefits | | | |
|---|---|---|---|
| Employee Amount | $10,000 (reduces to $7,500 at 65; $5,000 at 70) | Child Amount (6 mos to 26 yrs old) | $5,000 |
| Spouse Amount | $5,000 (terminates at age 70) | Infant Amount (15 days to 6 mos) | $1,000 |

| Short-Term Disability | | | |
|---|---|---|---|
| Benefit | 60% of base pay up to $150 per week | Waiting Period/Maximum Benefit Period | 7 days/26 weeks |

*[1] Once every 12 months [2] Once every 24 months [3] Single Vision: $25, Bifocal: $40, Trifocal: $55 [4] Discount on balance above allowed amount; Frames: 20%, Conventional Contact Lenses: 15%*

| Weekly Premiums | Dental | Vision | Term Life | STD |
|---|---|---|---|---|
| Employee Only | $5.40 | $2.42 | $0.60 | $4.20 |
| Employee + Child(ren) | $14.58 | $6.54 | $0.90 | n/a |
| Employee + Spouse | $10.80 | $4.84 | $0.90 | n/a |
| Employee + Family | $20.52 | $9.20 | $1.80 | n/a |

# Questions & Answers

**Q: Do all employees have to complete an enrollment form?**

A: Yes. By obtaining acknowledgement of either an acceptance or declination from each employee completes new-hire paperwork, you are limiting the liability you and your employer face. We never want an employee or family member of your agency to come back to you and say they were discriminated against and never offered insurance. It is in your company's best interest to make sure that all employees fill out the enrollment form and either elect or decline coverage.

**Q: When can an employee enroll for benefits?**

A: Employees may sign up for coverage during their first thirty (30) days of employment or during the company-wide open enrollment period. Employees who choose not to elect coverage during their own 30-day open enrollment period, or a company-wide open enrollment, will be asked to wait until the next company-wide open enrollment period before being allowed to elect coverage. Leaving one job assignment and immediately starting another does not constitute a "new" 30-day open enrollment period. If an employee has been terminated or laid off from an assignment and returns on a new assignment, after 6 or more weeks, he/she may re-enroll as a new hire. ESC/PAI considers an employee's first day on a job assignment, regardless of length, the start of their personal 30-day open enrollment period. This is why we encourage you to make sure ALL employees filling out new-hire paperwork complete an Essential StaffCARE enrollment form.

**Q: Will an employee's insurance be canceled if a premium payment is missed?**

A: No. Coverage cannot be cancelled until the employee has missed six consecutive premium deductions. In the event that an employee misses a deduction(s), the employee may make direct payments to PAI, as long as there has been at least one payroll deduction made through their employer. It is the employee's responsibility to contact PAI to make arrangements for direct payments. PAI will NOT contact your employee if a premium payment is missed. Employees may not initiate coverage through a direct payment. If an employee chooses not to make payments for the week(s) they have a break, no benefit will be paid for claims incurred and submitted during the break in coverage. Payments must be received within 45 days of the date of the paycheck from which a premium deduction would have been made. If an employee comes back to work between one (1) and six (6) weeks, payroll deductions will automatically begin again and be applied on a going forward basis (the Monday following the next deduction). Deductions will only be taken weekly and will NOT be "caught up" by the employer or posted to back weeks.

**Q: When will an employee and his/her eligible dependents be eligible for COBRA?**

A: Employees become eligible to receive a COBRA offer if they have had at least one payroll deduction through their employer and have missed six consecutive premium payroll deductions. Once there is a six week break with no payroll premium reported, a COBRA letter is automatically generated and sent by PAI to the member's home address. If the employee or dependent is eligible, he or she may elect COBRA within sixty days from the date of their letter and the applicable premium must be remitted in full to the address provided in their letter. COBRA participants or "qualified beneficiaries", are not billed for their COBRA payment and must take responsibility to keep premium current. COBRA participants may generally stay on COBRA for up to 18 months from the date of a qualifying event that causes loss of coverage. A second qualifying event may allow extended COBRA coverage for up to 36 months. Qualifying events for COBRA are termination of employment, loss of coverage due to a reduction of hours, death of the employee, divorce or legal separation, change in status of a dependent, Medicare entitlement, retired employees, and for employer bankruptcy.

**Q: Who is considered an "eligible dependent"?**

A: Your eligible dependents are your spouse and your children under age 26.

**Q: When can an enrollee add coverage for himself/herself or dependents?**

A: An enrollee may add coverage for himself/herself during an annual open enrollment period or during a life changing event, such as birth, marriage, death, divorce, adoption, Medicare entitlement or loss of prior coverage. Proof of the event must be provided and enrollment or change must occur within thirty days of such event.

# Our Networks

Please utilize the web site addresses or phone numbers below to locate a physician, dentist, or vision provider. DO NOT call with questions about your health plan. The networks do not have any knowledge of your medical plan.

## Medical Network

First Health Network
www.firsthealth.com
1-800-226-5116

## Prescription Network

Caremark Pharmacy Network
www.caremark.com
1-888-963-7290

## Dental Network

Dentemax
www.dentemax.com
1-800-752-1547

## Vision Network

EyeMed Vision Care
www.eyemedvisioncare.com
1-866-559-5252

# Ordering Materials

## Contact Essential StaffCARE to:

Adjust quantity of materials on restock, Stop Restock, and Order More Materials
**Phone Number:** 864-527-7929
**Email:** supplies@iagbenefits.com
**Website:** www.essentialstaffcare.com/supplies

## Restock

Upon request, your branch can receive an automatic recurring shipment (restock):

- Of English Enrollment Forms and/or Spanish Enrollment Forms
- Of Return Envelopes (for mailing employee applications to our third party administrator, PAI, for processing)
- All quantities can be adjusted for each branch's level of volume
- Restock is only adjustable in *quantities*, not frequency

If you choose to receive an automatic restock of forms, your forms will arrive every other month starting with your renewal month:

- If your plan renews in an odd month (Jan., March, May, July, Sept., Nov.), you will always receive restock in an odd month
- If your plan renews in an even month (Feb., April, June, Aug., Oct., Dec.), you will always receive restock in an even month
- **Example of how automatic restock works:** If your company renews your Indemnity plan in January, you will receive a *renewal* shipment in January with materials to hold Open Enrollment. You will then receive a *restock* of Enrollment Forms and Envelopes in March, May, July, Sept. and Nov.

## Order As Needed

If your branch does not wish to receive an automatic restock, you may order forms as your branch needs them:

- No more than six orders per year
- Materials can be ordered at any time, but please try to order enough forms to last 2-3 months
- All orders will be shipped ground with UPS and cannot be expedited
- You will be responsible for printing your own forms if you do not allow enough time for shipping
- All shipments are mailed from Greenville, SC (29615)
- Visit *www.ups.com/maps* to see an estimated shipment time
- Please allow 1-2 days for printing

## How to Submit Enrollment Forms

- Electronic Submission via Secure Site (2 business days)
  - *Most reliable way to submit for quick processing*
  - *Please contact service@iagbenefits.com to verify your FTP site*
- Faxing (4 business days)
  - *Please use Fax Cover Sheet on page 10*
- By Mail (up to 10 business days)
- **Please submit enrollment forms on a weekly basis. This will ensure benefit activation in a timely manner, as well as increase Compliance.**

# New Hire Procedures

1. All new hires who complete an I-9 and W-4 will need to complete the ESC enrollment form. Please incorporate the Essential StaffCARE (ESC) enrollment form into your New Hire paperwork.
2. Ask your employees to complete the form to the best of their knowledge.
3. Every new hire must check **'Yes' or 'No'** on the enrollment application.
4. Don't let employees take the application portion of the form home.
5. Check the form for completeness. We must have all personal information on the top portion of the application including:
    - Social Security Number
    - Date of Birth
    - First and Last Name
    - Home Phone Number
    - Address
    - Dependent information if dependent coverage is elected.
    - Signature and Date
    - Election of 'Yes' or 'No'
6. Any information left off of the top portion of the enrollment form may delay coverage for the employee.
7. Fax the completed forms to PAI's secure fax at 1-803-264-0772. Please include a fax cover sheet alerting PAI how many applications are included in the fax transmission. You will find, enclosed, a fax cover template which includes important information to accompany your fax. Please feel free to use this version, or create your own.
8. If you prefer to mail your enrollment forms to PAI at least once a week, we will supply you with postage paid return envelopes.

Ask your employees to fill out the Essential StaffCARE enrollment form to the best of their knowledge and hand the benefit election portion back to you. Do not allow this portion to leave your office. Your new hire employee may take the remainder of the form home with them. The take home portion contains valuable information about their plan and also how they can make changes until they receive their ID card and Summary Plan Description from Planned Administrators.

Please do not let the benefit election portion of the enrollment form leave your office--- the chances of getting the form back within the eligibility period is slim and also leaves your company open for a liability. If an employee is unsure of the type of coverage they need, have them complete the top portion of the enrollment form with all personal information and check the box titled "No to all benefits" They can take the remaining portion home with them to discuss with family members. If the employee would like to change their initial election, the take home portion of the application will alert them on how this may be done. They can use our Interactive Voice Response (IVR) system, or they may call the Essential StaffCARE Customer Service line directly, and a customer service representative will assist them in making changes.

Planned Administrators will do all the tracking of your employee's eligibility through their systems. We are receiving weekly payroll files from your corporate office, therefore we are able to monitor when deductions and benefits will begin. That is why we must insist that the Essential StaffCARE enrollment form be completed at the time the new hire paperwork is done and faxed to PAI at 1-803-264-0772 no less than once a week. Enrollment forms are date stamped upon receipt at PAI and keyed into the system within 4 business days. Once an employee has received an assignment, PAI will communicate back to your corporate office as to when premium deductions will begin.

# ENROLLMENT FORMS
# FAX COVER SHEET

## GROUP #276100-LGS

NUMBER OF PAGES BEING FAXED (INCLUDING COVER PAGE) ______________________

YOUR NAME ______________________

YOUR PHONE NUMBER ______________________

Please Fax to **ONE** of the following. Indicate which fax line you are using by checking the box below.

PAI's FAX NUMBERS:
- ☐ 1-803-264-0772
- ☐ 1-803-264-8571
- ☐ 1-803-264-8739
- ☐ 1-803-870-8060

| VSI | OFFICE USE ONLY | LOCATION ____________ | Rehire Date __ __/__ __/__ __ __ __ |
|---|---|---|---|

# ENROLLMENT FORM

ESC/MEC 4US P2M v20.1

## A. REQUIRED EMPLOYEE INFORMATION

**PRINT USING BLACK or BLUE INK (Must Be Filled Out)**

| Name | Home Phone | |
|---|---|---|
| Social Security # | Date of Birth / / | Gender M F |
| Address | | Apt. # |
| City | Zip | State |

## B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare benefits?

☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

## C. LIMITED BENEFIT PLAN SELECTION

**Payroll Deducted Weekly Rates**

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for all the benefits in Section C will be identical. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

| SELECT COVERAGE LEVEL | | FIXED INDEMNITY MEDICAL [1] | DENTAL | VISION | TERM LIFE | SHORT-TERM DISABILITY [2] |
|---|---|---|---|---|---|---|
| Employee Only | ☐ | $20.91 | $5.40 | $2.42 | $0.60 | $4.20 |
| Employee + Child(ren) | ☐ | $34.71 | $14.58 | $6.54 | $0.90 | |
| Employee + Spouse | ☐ | $39.73 | $10.80 | $4.84 | $0.90 | |
| Employee + Family | ☐ | $52.90 | $20.52 | $9.20 | $1.80 | |
| **NO** to ALL Benefits | ☐ | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

**For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.**

Name Relationship

## D. REQUIRED DEPENDENT INFORMATION

| Name | Social Security # | Date of Birth | Gender | Relationship |
|---|---|---|---|---|
| Name | Social Security # | Date of Birth / / | Gender M F | ☐ Spouse ☐ Child ☐ Domestic Partner |
| Name | Social Security # | Date of Birth / / | Gender M F | ☐ Spouse ☐ Child ☐ Domestic Partner |
| Name | Social Security # | Date of Birth / / | Gender M F | ☐ Spouse ☐ Child ☐ Domestic Partner |

## E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

**Direct Payment Monthly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ **$58.19** Employee Only ☐ **$65.79** Employee + Child(ren) ☐ **$71.00** Employee + Spouse ☐ **$80.87** Employee + Family

☐ **NO** to MEC Wellness/Preventive

ACA

## F. REQUIRED SIGNATURE

**YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE**

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage.

**DATE** __ __/__ __/__ __ __ __ ▶ **SIGNATURE**

SAMPLE

Essential StaffCARE | PLAN 2 - CHANGE FORM | 276100-LGS

Mail / Fax to: Planned Administrators, Inc.
PO Box 6702
Columbia, SC 29260

Telephone (866) 798-0803
Fax (803) 264-0772

Underwritten by
BCS Insurance Company
Oakbrook Terrace, IL

Fill out this form ONLY if you are making changes in your coverage or terminating coverage.

## A. REASON FOR THE CHANGE

☐ Address Change ☐ Name Change ☐ Add Dependent(s) ☐ Coverage Change ☐ Terminate Coverage

## B. REQUIRED EMPLOYEE INFORMATION

**MUST BE FILLED OUT** **Address/Name Change**

| Name | Social Security # | Home Phone | | Gender M F |
|---|---|---|---|---|
| Address | City | State | Zip | Apt. # |
| Employer | | Hire Date / / | | Date of Birth / / |

**Add/Change Dependent Information**

| Name | Social Security # | Date of Birth | Gender | Relationship |
|---|---|---|---|---|
| | | / / | M F | |
| | | | M F | |
| | | | M F | |

## C. INDEMNITY PLAN CHANGES - Select the change you wish to make for each benefit

**Weekly Rates**

You **MUST** select a coverage level before adding any benefits in Section C. Your coverage level for all the benefits in Section C will be identical.

| SELECT COVERAGE LEVEL | FIXED INDEMNITY MEDICAL [1] | DENTAL | VISION | TERM LIFE | SHORT-TERM DISABILITY [2] |
|---|---|---|---|---|---|
| Employee Only ☐ | **$20.91** | **$5.40** | **$2.42** | **$0.60** | **$4.20** |
| Employee + Child(ren) ☐ | **$34.71** | **$14.58** | **$6.54** | **$0.90** | |
| Employee + Spouse ☐ | **$39.73** | **$10.80** | **$4.84** | **$0.90** | |
| Employee + Family ☐ | **$52.90** | **$20.52** | **$9.20** | **$1.80** | |
| Terminate **All** Plans ☐ | ☐ Enroll | ☐ Enroll | ☐ Enroll | ☐ Enroll | ☐ Enroll |
| No Change to Any Plan ☐ | ☐ Cancel | ☐ Cancel | ☐ Cancel | ☐ Cancel | ☐ Cancel |
| | ☐ No Change | ☐ No Change | ☐ No Change | ☐ No Change | ☐ No Change |

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

Add/Change Life/Accidental Loss of Life, Limb and Sight Beneficiary

| Primary | Relationship |
|---|---|
| Secondary | Relationship |

## D. MEC PLAN CHANGES - Select the change you wish to make.

82761000-M-LGS **Monthly Rates**

**MEC Wellness/Preventive** ☐ **Terminate** MEC Plan ☐ No Change

☐ **$58.19** Employee Only ☐ **$65.79** Employee + Child(ren) ☐ **$71.00** Employee + Spouse ☐ **$80.87** Employee + Family

I understand that coverage may continue under my old elections until this form is received and processed by PAI. If electing benefits for the MEC plan, I hereby authorize my employer to send an enrollment request to PAI. I understand that a change in elections will be effective the 1st of the month following your credit card draft. If canceling, your coverage will terminate on the last day of the month for which a payment has been made. I understand that I have been offered an opportunity to become covered under the Essential StaffCARE plans, and I have chosen NOT to take advantage of this offer.

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**

| Essential StaffCARE | PLAN 2 - FORMULARIO DE CAMBIOS | 276100-LGS |
|---|---|---|

Enviar por correo/fax a: Planned Administrators, Inc. PO Box 6702 Columbia, SC 29260

Teléfono (866) 798-0803
Fax (803) 264-0772

Con el aval de BCS Insurance Company Oakbrook Terrace, IL

Llene este formulario SÓLO si va a hacer cambios a la cobertura o a cancelarla.

## A. RAZÓN DEL CAMBIO

☐ Cambio de dirección ☐ Cambio de nombre ☐ Agregar dependiente(s) ☐ Cambio de cobertura ☐ Cancelar la cobertura

## B. INFORMACIÓN REQUERIDA DEL EMPLEADO

**CONTESTAR TODO** **Cambio de dirección/nombre**

| Nombre | # de Seguro Social | Teléfono | | Género ☐H ☐M |
|---|---|---|---|---|
| Dirección | Ciudad | Estado | Código Zip | Apt. # |
| Empleador | | Fecha de contratación / / | | Fecha de nacimiento / / |

**Agregar/cambiar información de dependientes**

| Nombre | # de Seguro Social | Nacimiento | Género | Relación |
|---|---|---|---|---|
| | | / / | ☐H ☐M | |
| | | | ☐H ☐M | |
| | | | ☐H ☐M | |

## C. CAMBIOS AL PLAN DE COMPENSACIÓN FIJA - Elija el cambio que quiere en cada beneficio

**Pagos semanales**

Usted **DEBE** seleccionar un nivel de cobertura antes de añadir ningún beneficio de la Sección C. Su nivel de cobertura será idéntica para cada beneficio de la Sección C.

| SELECCIONE NIVEL DE COBERTURA | | PLAN MÉDICO [1] | PLAN DENTAL | PLAN DE LA VISTA | SEGURO DE VIDA | DISCAPACIDAD A CORTO PLAZO [2] |
|---|---|---|---|---|---|---|
| Solo empleado | ☐ | **$20.91** | **$5.40** | **$2.42** | **$0.60** | **$4.20** |
| Empleado + Hijo(s) | ☐ | **$34.71** | **$14.58** | **$6.54** | **$0.90** | |
| Empleado + Esposa/o | ☐ | **$39.73** | **$10.80** | **$4.84** | **$0.90** | |
| Empleado + Familia | ☐ | **$52.90** | **$20.52** | **$9.20** | **$1.80** | |
| Terminar toda cobertura | ☐ | ☐ Registrarse | ☐ Registrarse | ☐ Registrarse | ☐ Registrarse | ☐ Registrarse |
| Sin cambio | ☐ | ☐ Cancelar | ☐ Cancelar | ☐ Cancelar | ☐ Cancelar | ☐ Cancelar |
| | | ☐ Sin cambio | ☐ Sin cambio | ☐ Sin cambio | ☐ Sin cambio | ☐ Sin cambio |

[1] Cobertura no disponible a residentes de NH, HI o PR. [2] Beneficios de discapacidad a corto plazo no disponibles a trabajadores de CA, HI, NJ, NY o RI.

Agregar/cambiar al beneficiario del seguro de vida y del seguro por pérdida de la vida, de un miembro o de la vista por accidente

| Primario | Relación |
|---|---|
| Secundario | Relación |

## D. CAMBIOS AL PLAN MEC - Seleccione el cambio que quiere hacer

82761000-M-LGS **Pagos mensuales**

**MEC Wellness/Preventive** ☐ **Cancelar** el Plan MEC ☐ Sin cambio

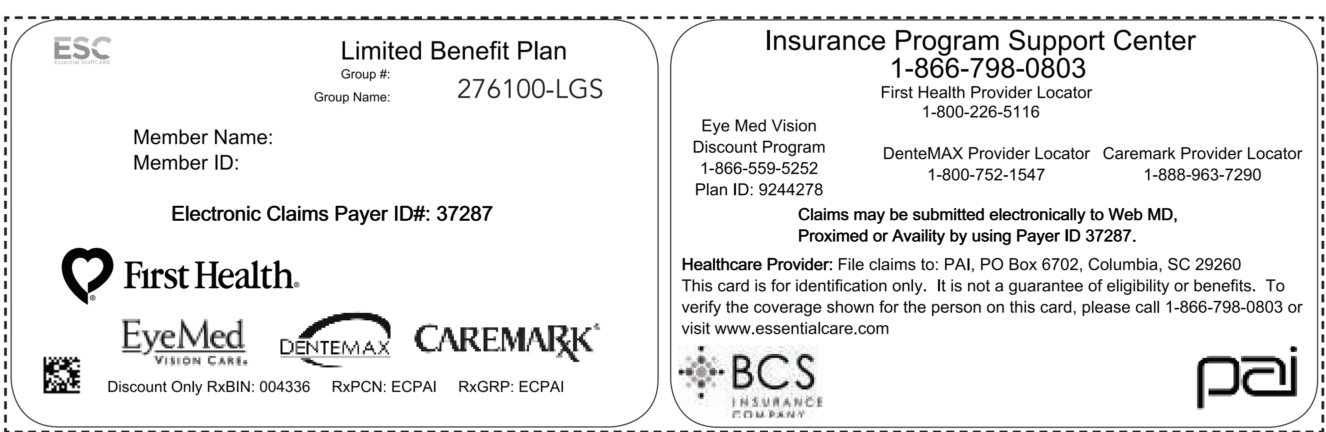
☐ **$58.19** Solo empleado ☐ **$65.79** Empleado + Hijo(s) ☐ **$71.00** Empleado + Esposa/o ☐ **$80.87** Empleado + Familia

Entiendo que la cobertura puede continuar durante mis elecciones anteriores hasta que este formulario sea recibido y procesado por PAI. Si elije beneficios para el plan de MEC, por la presente autorizo a mi empleador a enviar una solicitud de inscripción a PAI. Entiendo que un cambio en las elecciones será efectivo el día 1 del mes siguiente al borrador de su tarjeta de crédito. Si cancela, su cobertura terminará el último día del mes para el cual se haya realizado un pago. Entiendo que se me ha ofrecido la oportunidad de cubrirme con los planes de Essential StaffCARE, y he decidido NO aprovechar esta oferta.

FECHA __ __ /__ __ /__ __ __ __ ▶ **FIRMA**

## Dear Enrollee:

Welcome to the Essential StaffCARE Benefit Plan! Included you will find a temporary ID Card that will allow you access to Essential StaffCARE Benefits until you receive your permanent ID Card. You should receive your permanent ID Card within a few weeks of your coverage effective date. Your member ID number is your Social Security Number.




ID Card - Cut on the dotted lines and then fold down the middle

**Q: After I sign up, when will my coverage go into effect?**

A: Your coverage goes into effect the Monday following your first payroll deduction. Coverage can not be initiated with a pre-payment.

**Q: How do I find an in-network physician or hospital?**

A: While your medical plan does not impose an in-network restriction, you may realize additional savings by utilizing an in-network medical provider.

First Health Network - www.firsthealthnetwork.com - 1-800-226-5116

**Q: Is there a phone number my doctor can call to get a list of my benefits?**

A: Yes, your provider may call the Essential StaffCARE Customer Service number 1-866-798-0803 for scheduled benefits and benefit maximums.

**Q: What if I need to have a prescription filled?**

A: For generic and brand prescriptions, present your ID card at a participating pharmacy to receive discounts. Generic and brand prescriptions are payable based on the schedule of benefits up to the annual prescription drug maximum. To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc. Prescription drug coverage is not provided for drugs administered during a physician office visit or hospital stay.

**Q: Where can I get claim forms?**

A: Medical and Dental claim forms may be obtained by calling our customer service line at 1-866-798-0803 or you may download claim forms from our website – www.paisc.com. Be sure to click on Essential StaffCARE on the welcome page.

**Q: What if I want to cancel or make changes to my coverage?**

A: Coverage may be canceled or reduced at any time, unless your employer takes premium deductions pre-tax. To make changes or cancel coverage by telephone call (800) 269-7783 within 30 days of the date of your first paycheck. You will be prompted to enter your PIN CODE plus the last four digits of your Social Security number (SSN).

**PIN CODE:** 142 + _ _ _ _ (last four digits of your SSN)

# Reference Manual

## Information for Branch Managers on **MEC Wellness/Preventive Plan**

Schedule of Benefits ........................................ **16**
Questions with Answers ........................................ **18**
Payment Information ........................................ **19**
Summary of Benefits and Coverage Document ........................................ **20**

# MEC Wellness/Preventive Benefits

| Adults - The MEC Plan covers 100% of the allowed amount in network; 40% out of network | |
|---|---|
| **Abdominal Aortic Aneurysm** | One time screening for men of specified ages who have ever smoked |
| **Alcohol Misuse** | Screening and counseling |
| **Aspirin** | Use for men and women of certain ages |
| **Blood Pressure** | Screening for all adults |
| **Cholesterol** | Screening for adults of certain ages or at higher risk |
| **Colorectal Cancer** | Screening for adults over 50 |
| **Depression** | Screening for adults |
| **Type 2 Diabetes** | Screening for adults with high blood pressure |
| **Diet** | Counseling for adults at higher risk for chronic disease |
| **HIV** | Screening for all adults at higher risk |
| **Immunization** | Vaccines for adults' doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella |
| **Obesity** | Screening and counseling for all adults |
| **Sexually Transmitted Infection (STI)** | Prevention counseling for adults at higher risk |
| **Tobacco Use** | Screening for all adults and cessation |
| **Syphilis** | Screening for all adults at higher risk |
| **Women, Including Pregnant Women - The MEC Plan covers 100% of the allowed amount in network; 40% out of network** | |
| **Anemia** | Screening on a routine basis for pregnant women |
| **Bacteriuria** | Urinary tract or other infection screening for pregnant women |
| **BRCA** | Counseling about genetic testing for women at higher risk |
| **Breast Cancer Mammography** | Screenings every 1 to 2 years for women over 40 |
| **Breast Cancer Chemoprevention** | Counseling for women at higher risk |
| **Breastfeeding** | Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women |
| **Cervical Cancer** | Screening for sexually active women |
| **Chlamydia Infection** | Screening for younger women and other women at higher risk |
| **Contraception** | Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs |
| **Domestic and Interpersonal Violence** | Screening and counseling for all women |
| **Folic Acid** | Supplements for women who may become pregnant |
| **Gestational Diabetes** | Screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes |
| **Gonorrhea** | Screening for all women at higher risk |
| **Hepatitis B** | Screening for pregnant women at their first prenatal visit |
| **Human Immunodeficiency Virus (HIV)** | Screening and counseling for sexually active women |
| **Human Papillomavirus (HPV) DNA Test** | High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older |
| **Osteoporosis** | Screening for women over age 60 depending on risk factors |
| **Rh Incompatibility** | Screening for all pregnant women and follow-up testing for women at a higher risk |
| **Tobacco Use** | Screening and interventions for all women, and expanded counseling for pregnant tobacco users |
| **Sexually Transmitted Infections (STI)** | Counseling for sexually active women |

# MEC Wellness/Preventive Benefits

| | |
|---|---|
| **Syphilis** | Screening for all pregnant women or other women at increased risk |
| **Well-Woman Visits** | To obtain recommended Preventive services for women under 65 |
| **Children - The MEC Plan covers 100% of the allowed amount in network; 40% out of network** | |
| **Alcohol and Drug Use** | Assessments for adolescents |
| **Autism** | Screening for children at 18 and 24 months |
| **Behavioral** | Assessments for children of all ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years |
| **Blood Pressure** | Screenings for children: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 yers; 15 to 17 years |
| **Cervical Dysplasia** | Screening for sexually active females |
| **Congenital Hypothyroidism** | Screening for newborns |
| **Depression** | Screening for adolescents |
| **Developmental** | Screening for children under age 3, and surveillance throughout childhood |
| **Dyslipidemia** | Screening for children at higher risk of lipid disorders. Ages: 1 to 4 years; 5 to 10 years; 11 to 14 years; and 15 to 17 years |
| **Fluoride Chemoprevention** | Supplements for children without fluoride in their water source |
| **Gonorrhea** | Preventive medication for the eyes of all newborns |
| **Hearing** | Screening for all newborns |
| **Height, Weight, and Body Mass Index** | Measurements for children ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years |
| **Hematocrit or Hemoglobin** | Screening for children |
| **Hemoglobinopathies** | Or Sickle Cell screening for newborns |
| **HIV** | Screening for adolescents at higher risk |
| **Immunization** | Vaccines for children from birth to age 18-- doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae Type B, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella |
| **Iron** | Supplements for children ages 6 to 12 months at risk for anemia |
| **Lead** | Screening for children at risk of exposure |
| **Medical History** | For all children throughout development: Ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years |
| **Obesity** | Screening and counseling |
| **Oral Health** | Risk assessment for young children: Ages: 0 to 11 months; 1 to 4 years; 5 to 10 years |
| **Phenylketonuria (PKU)** | Screening for this genetic disorder in newborns |
| **Sexually Transmitted Infection (STI)** | Prevention counseling and screening for adolescents at higher risk |
| **Tuberculin** | Testing for children at higher risk of tuberculosis: Ages 0 to 11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; and 15 to 17 years |
| **Vision** | Screening for all children |

| MEC Monthly Rates | |
|---|---|
| **Employee Only** | **$58.19** |
| **Employee + Child(ren)** | **$65.79** |
| **Employee + Spouse** | **$71.00** |
| **Employee + Family** | **$80.87** |

# MEC Wellness/Preventive Plan Questions & Answers

**Q: How do I enroll?**

**A:** Enrolling in the MEC Wellness/Preventive Plan is easy. You can enroll by completing an Essential StaffCARE MEC Wellness/Preventive Plan application and returning it to your manager.

**Q: When can I enroll in the plan?**

**A:** You are eligible to enroll in the MEC Wellness/Preventive Plan program within 30 days of your hire date or during your employer's annual 30 day open enrollment period. If you do not enroll during one of these time periods, you will have to wait until the next annual open enrollment, unless you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

**Q: What is a qualifying life event?**

**A:** A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Death of an immediate family member
- Medicare entitlement
- Employer bankruptcy
- Loss of dependent status
- Loss of prior coverage

In addition, you may request a special enrollment (for yourself, your spouse, and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this benefit.

**Q: Are dependents covered?**

**A:** Yes. Eligible dependents include your spouse and your children up to age 26.

**Q: When does coverage begin?**

**A:** Coverage begins the 1st of the month following receipt of your first monthly payment.

**Q: Can I make changes or cancel coverage?**

**A:** You will only have 30 days from your hire date to enroll, add additional benefits or add additional insured members. After this time frame, you will only be allowed to enroll, add benefits or add additional insured members during your annual open enrollment period or within 30 days of a qualifying life event.

**Q: How can I make changes or enroll if I initially decline?**

**A:** To make changes or enroll if you initially declined, contact your employer and request a change form. Changes are effective the 1st of the month following the date of the change request. You can cancel or reduce coverage at any time. Please remember that you may only enroll or increase your coverage level during an open enrollment period or within 30 days of a qualifying life event.

**Q: Is there a pre-exisiting clause for the medical benefit?**

**A:** There are no restrictions for pre-existing conditions in this plan. Even if you were previously diagnosed with a condition, you can receive coverage for related services as soon as your coverage goes into effect.

# Direct Payment Information

## Step 1

Once a paycheck date is reported to PAI, a Confirmation of Coverage (COC) letter or (possibly) email will go to employees who completed a MEC enrollment form with instructions for setting up credit card payments. PAI accepts credit card, debit cards or prepaid cards, as long as there is one of the following credit card brand logos on the card: Visa, Mastercard, or Discover.

## Step 2

Employees will log into a page on the PAI website to enter their credit card information. This credit card information will **not** be saved on PAI's server.

PAI will pass the credit card data to our sister company, PHT (Preferred Health Technologies), who specializes in these transactions.

## Step 3

PAI will send a monthly file to PHT on the 15th of every month to charge the employees' credit card. Charges made to the employees' credit cards are for coverage for the following month.

MEC enrollment is effective the first day of the month following the first credit card draft.

# Minimum Essential Coverage

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.paisc.com or by calling 1-866-798-0803.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** person / **$0** family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | No | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Not applicable | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No | The plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits. |
| **Does this plan use a network of providers?** | Yes. First Health Network and Caremark | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes | Some of the services this plan doesn't cover are listed on page **5**. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Not Covered | | Not Applicable |
| | Specialist visit | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Other practitioner office visit | | | |
| | Preventive care/screening/immunization | | | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.paisc.com | Generic drugs | No Charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty Drugs | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room services | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Emergency medical transportation | Not Covered | | |
| | Urgent care | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Covered | | |
| | Physician/surgeon fee | | | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Mental/Behavioral health inpatient services | Not Covered | | |
| | Substance use disorder outpatient services | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Substance use disorder inpatient services | Not Covered | | |
| **If you are pregnant** | Prenatal and postnatal care | No charge for preventive services as outlined by the Affordable Care Act | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Delivery and all inpatient services | Not Covered | | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | | |
| | Rehabilitation services | | | |
| | Habilitation services | | | |
| | Skilled nursing care | | | |
| | Durable medical equipment | | | |
| | Hospice service | | | |
| **If your child needs dental or eye care** | Eye exam | No charge for preventive services as outlined by the Affordable Care Act (for children only) | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |
| | Glasses | Not Covered | | |
| | Dental check-up | No charge for preventive services as outlined by the Affordable Care Act (for children only) | | This plan provides benefits for Preventive Services as outlined by the Affordable Care Act |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Routine eye care (children only)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-798-0803. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: PAI at 1-866-798-0803 or your employer's human resources department. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-798-0803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-798-0803
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-798-0803
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-798-0803.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $940.00
- **Patient pays** $ 6,600

**Sample care costs:**

| Item | Cost |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| Item | Cost |
|---|---|
| Deductibles | $0 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $6,600 |
| **Total** | **$6,600** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $200.00
- **Patient pays** $ 5,200

**Sample care costs:**

| Item | Cost |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| Item | Cost |
|---|---|
| Deductibles | $0 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $5,200 |
| **Total** | **$5,200** |

# Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.